AFFORDABLE CARE ACT MARKETPLACE ENROLLMENT: MITIGATING THE BARRIERS THAT ASSISTERS FACE IN ENROLLING IMMIGRANT POPULATIONS IN NORTH CAROLINA

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5/5/2015

INTRODUCTION

Immigrant Health in North Carolina

In the last 20 years, the number of foreign-born residents in the United States has doubled from 20 million in 1990 to 40 million in 2010. Approximately 710,000 immigrants reside in North Carolina and 33% of these immigrants are naturalized citizens (have lawful citizen status). Most of foreign-born North Carolinians are from Latin America (~421,000) and Asia (~179,000) (Johnson Jr & Appold, 2014). In general, immigrants have better health than the average American when they first enter the country. However, it is common for an immigrant's health status to decline in relation to length of time in the U.S. (Derose, Escarce, & Lurie, 2007). Foreign-born residents are less likely to have a regular source of care and tend to use emergency rooms more frequently as a source of care than their native-born counterparts (Derose, Bahney, Lurie, & Escarce, 2009).

Foreign-born residents have a lower mean earnings and are more likely to live in poverty than native-born residents. However, they are less likely than the native-born to rely on public sources for health insurance coverage and significantly less likely to be covered by health insurance than the general population (48.4% compared to 81.6%) (Johnson Jr & Appold, 2014). This is due, in part, to Medicaid eligibility restrictions for immigrants and foreign-born populations. The barriers that foreign-born populations face when seeking care and health insurance coverage greatly depend on their legal status and circumstances. Lack of health insurance coverage contributes to diminished health, quality of care, and access to care (Derose et al., 2009) (The Kaiser Family Foundation, 2001). However, the Patient Protection and Affordability Act, also known as The Affordable Care Act (ACA) and "Obamacare," attempts to mitigate this disparity for many immigrants and foreign-born populations who reside in the U.S. legally.

Affordable Care Act

The ACA was signed into U.S. law by President Barak Obama on March 23, 2010 and has significant implications for providers, payers, and consumers. It amends many facets of the health system and seeks to improve quality and performance. Overall, the law broadly focuses on controlling healthcare costs, improving quality of care, advancing population health, and expanding health insurance coverage and access to services.

In order to expand coverage and access to healthcare, the ACA mandates that most citizens and legal immigrants obtain health insurance coverage in 2014 or face a tax penalty. In 2013, approximately 1,584,300 North Carolinians under the age of 65 were uninsured (The Kaiser Family Foundation, 2013). The ACA allowed state governments to extend eligibility for Medicaid coverage to more low-income adults (with incomes up to 138% of the federal poverty level (FPL), but North Carolina chose not to expand its program. In addition, a major portion of the ACA focuses on the creation of marketplaces—either state-based or federally facilitated— where both small employers and individual consumers can enroll in qualified health insurance plans. The marketplace provides standard information to assist consumers in choosing between health plans. It also determines a consumer's eligibility for premium tax credits and cost-sharing subsidies, which are offered on a sliding scale based on a consumer's income. North Carolina, along with

thirty-five other states, decided to use the federally facilitated marketplace (The Kaiser Family Foundation, 2014). From October 1, 2013- April 19, 2014, 357,584 North Carolinians enrolled in health plans through the marketplace.

Upon implementation of the ACA, North Carolina became a "non-embracing state" by demonstrating political resistance and little effort by the state government to raise awareness, educate the broad public, reach special populations, and facilitate the enrollment process. Even still, North Carolina achieved the ninth highest rate of enrollment nationwide after Open Enrollment 1. Compared to other non-embracing states, North Carolina achieved the third highest rate of enrollment (Silberman, 2014). Much of the success can be attributed to the work of community-based organizations and a network known as the NC Get Covered Coalition, formerly known as "The Big Tent", which is made of different stakeholders working on outreach, education, and enrollment. Members included representatives of navigator organizations, Federally Qualified Health Centers (FQHCs), Certified Application Counselor organizations (CACs), insurance agents and brokers, representatives of insurance carriers participating in the Marketplace, and other interested organizations and individuals. Together they shared information, identified workarounds to common problems, and promoted ACA enrollment. In addition, the national non-profit Enroll America contributed to statewide education and enrollment in North Carolina and in other states that use the federally facilitated marketplace and have large populations of uninsured people. The combined effort of North Carolina's community organizations has been championed across the country given the success of the last enrollment (Warren, 2014).

Enrollment

Enroll America found that during the first open enrollment period (October 1, 2013- March 31, 2014) consumers were twice as likely to enroll if they received in-person assistance. Only about 16% of people were able to enroll successfully without assistance (Enroll America, 2014). As indicated by Enroll America's findings, assisters play a vital role in the success of North Carolina's enrollment statistics. Assisters varied on their level of training, their status, and the type of organization and circumstances under which they aided enrollment.

As assisters guided consumers through the marketplace, they were faced with many challenges (Volk, Corlette, Ahn, & Brooks, 2014). Furthermore, while some barriers to enrolling the consumer were somewhat common across most appointments (i.e. technical problems), other issues were as unique as the consumer. In particular, immigrants presented assisters with a myriad of challenges due to a variety of access and eligibility issues. Many of these problems have not been resolved; successfully enrolling immigrants is an on-going challenge (Pollitz & Tolbert, 2014). It is important to determine what issues assisters are confronting in trying to enroll these populations and what is known about how to best mitigate these barriers.

Research Questions

1. What do assisters perceive to be the barriers to enrolling Latino immigrants, temporary migrant workers, and non-immigrant refugees in the ACA?
2. What are the best practices for assisters to mitigate these barriers and help these populations successfully enroll into the Marketplace?

LITERATURE REVIEW

Immigrant Health in North Carolina

Immigrants face unique challenges in obtaining the insurance coverage needed to help pay for necessary healthcare services. In order to address these challenges, it is important to understand who immigrants are, the factors that impact their ability to access health services in the U.S., and why it is important to obtain health insurance.

The Immigration and Migration Act of 1965 ended discrimination in granting citizen status based on country of origin. Prior to 1965, the United States gave preference to immigrants coming from certain regions, such as northern and western Europe. This act had long term implications for immigration demographics. Origin demographics have changed drastically between 1990 and 2012. Beginning in the 1990s, employers in North Carolina began to seek inexpensive labor by recruiting international workers, primarily from Mexico and Central America. As of 2010, due to heightened security measures along the U.S. – Mexico borders, the rate of immigration from Latin America dropped and the rate from Asia has increased. Table 1 shows the specific countries of origin for North Carolina's foreign-born population (Johnson Jr. & Appold, 2014).

Table 1. Countries of Origin of Foreign-born North Carolina Population

Latin America		**Asia**		**Europe**		**Africa**		**Other**	
Total	421,149	178,722		82,186		46,033		19,982	
Mexico	268,586 (63.8%)	India	42,522 (23.8%)	United Kingdom	24,131 (29.4%)	Nigeria	5,129 (11.3%)	Canada	15,695 (78.5%)
El Salvador	27,627 (6.6%)	China	26,094 (14.6%)	Germany	14,046 (17.1%)	Liberia	4,044 (8.8%)	Oceania	4,110 (20.5%)
Honduras	22,530 (5.4%)	Vietnam	25,119 (14.1%)	Russia	6,329 (7.7%)	South Africa	3,525 (7.7%)	Other	177 (.89%)
Other	102,406 (24.3%)	Korea	16,323 (9.1%)	Other	37,680 (45.8%)	Sudan	3,182 (6.9%)		
		Philippines	16,233 (9.1%)			Egypt	2,587 (5.6%)		
		Other	52,341 (29.3%)			Other	27,566 (59.9%)		

Source: Johnson Jr & Appold, Data originally retrieved from American Community Survey 2012, 5 Year estimates

Non-native individuals residing in the U.S. have an array of immigrant or non-immigrant statuses, depending on their reason for being in the country and their individual circumstances. Unlike Medicaid, which has very restrictive eligibility rules for immigrants, the ACA allows almost all immigrants with legal status to gain insurance coverage in the Marketplace. These lawfully residing immigrants are also eligible for premium tax credits and cost sharing subsidies. Ironically, immigrants who are lawfully present are eligible for subsidies if their income is less than 100% FPL during their first five years in the country, because they are not eligible for Medicaid during the first five years, with a few exceptions. In contrast, citizens are not eligible for subsidized coverage in the Marketplace if their income is less than 100% FPL. Appendix A

provides a list of categories of immigrants who are eligible to purchase insurance in the ACA Marketplace.

Fifty percent of North Carolina's foreign-born population fall between the ages of 25-44 (prime working years), compared to 25% of the native-born population. In 2010, 42.5% of immigrants had a high school degree or less (Johnson Jr & Appold, 2014). Immigrants participate in the civilian labor force at a higher rate than native-born residents (71% vs. 61%), yet their occupations tend to be significantly more risky (Orrenius & Zavodny, 2009). These jobs often pay less on average than the jobs that their native-born counterparts hold. Foreign-born families are twice as likely to live in poverty as native-born families (Johnson Jr & Appold, 2014) . Low income jobs and blue collar jobs are much less likely to offer health insurance to their employees, which is how most Americans access health insurance (The Kaiser Family Foundation, 2013).

Despite a higher rate of poverty among this population, immigrants are less likely to use public programs such as Medicaid and the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance to Needy Families (TANF), which provide health, nutrition and economic support to low-income families (Perreira et al., 2012). It has been shown that these programs improve health and nutrition and contribute to stability in a household (Mills et. al., 2011). Eligibility regulations limit many legally residing immigrants from participating.

Prior to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) on August 28, 1996, legal immigrants were broadly considered eligible for public benefits. However, PRWORA restricted access to Medicaid and the Child Health Insurance Program (CHIP) in a variety of ways. Under this law, legal immigrants were classified into two groups: qualified and unqualified. Qualified legal immigrants were deemed eligible on the basis of their time of arrival in U.S. (before enactment of PRWORA or after) and the length of residency in the U.S. (less than or greater than 5 years). Legal permanent residents (LPRs) who arrived prior to August 28, 1996 or who had arrived after *and* resided within the U.S. for more than 5 years are *generally* eligible. Most LPRs who have been in the United States for less than five years are ineligible for Medicaid and CHIP (although states can choose to cover LPR children and pregnant women who have resided in the US for less than five years). Certain refugees and asylees receive 8 months of Medicaid coverage upon their arrival in the U.S. They are not subject to the 5 year requirement if they meet the income and family eligibility requirements. Within this group, low-income single adults without children lose eligibility after 8 months because they do not meet the regular Medicaid eligibility rules (this group is comprised largely of single, childless men). For all immigrants, eligibility is determined on an individual basis rather than a family basis, so some members of a family could be considered eligible given the correct combination of immigration status, time of arrival, and length of residence while their family members remain ineligible (Perreira et al., 2012).

Some states, including North Carolina, administer their programs on a "county-administered, state-supervised" basis, which can lead to variability in the administration of the programs, potentially affecting immigrant services in a variety of ways. A few examples of potential differences from place-to-place include design of outreach materials, availability of interpreters, experience in working with the immigrant population, different staffing ratios, resources, and enforcement of immigration law (Perreira et al., 2012). These variables can lead to confusion among the immigrant populations because experiences with one office may be different

from another. In addition, undocumented immigrants in "mixed-status" families (e.g, a family with both qualified immigrants and undocumented immigrants) may have a fear that a member would be reported to the U.S. Immigration and Customs Enforcement (ICE) during a Medicaid or NC Health Choice (North Carolina's Child Health Insurance Program) application. They may also worry that applying for these programs may adversely affect their ability to gain legal status (Woomer-Deters, 2014). Nationwide, 36% of all children who are eligible for Medicaid, but not enrolled in the program, live in immigrant families (Woomer-Deters, 2014).

Because of the difficulties qualifying for publicly-subsidized health insurance coverage and reduced access to employer-sponsored insurance, only approximately half of immigrants had insurance in 2012 (Johnson Jr & Appold, 2014). A lack of health insurance can have major health implications. It can impact when and where a person receives necessary medical care and their health status. The uninsured often forgo or postpone receiving healthcare services, and as a result, preventable conditions go undetected and untreated. They often face issues when trying to access care; over half of the uninsured have no regular source of care (The Kaiser Family Foundation, 2014). High healthcare costs reduce the feasibility of receiving care for anything that is not an absolute priority or an emergency. This leads to an increased likelihood of hospitalization for avoidable health problems and decreased overall health. Gaining coverage can lead to a revitalized health status (The Kaiser Family Foundation, 2014).

While immigrants generally have better health status than the average American citizen when they first arrive, their health tends to deteriorate with increased acculturation. This deterioration is due to a myriad of factors, such as lifestyle changes, living in unhealthy environments, and poor access to personal and public health services (Derose et al., 2009). Perreira et al. conducted a series of focus groups that targeted immigrants and refugees around North Carolina and found that although many participants experienced confusion around the topic of insurance and eligibility, 81% of the participants believed that healthcare insurance was an absolute necessity. Many reported difficulties in obtaining "critical medical care" or paying medical debts. Without insurance, many felt that they had no "peace of mind" (2014). The Affordable Care Act makes most legally residing immigrants eligible for health insurance in North Carolina (Healthcare.gov, 2014).

Special Considerations: Health Access for Migrant Workers and Refugees

Migrant Workers

Migrant workers are workers that travel away from their homes for extended periods of time to work, often in agriculture. Overall, migrant workers have a variety of legal statuses. Some may be citizens, others are immigrants that have documents which permit them to live and work in the United States, and still others are undocumented. A large portion work through the H2 Temporary Guest Worker Program, which provides foreigners with work visas to work in agriculture (H2-A visas) and other, non-agricultural (H2-B) industries. This study will refer to participants in the H2 Temporary Guest Worker Program as "temporary migrant workers" or simply as "migrant farmworkers." Each year North Carolina employs thousands of H2-A workers in agriculture and H2-B workers in forestry.

In general, the workers are typically young (an average age of 36), men (78%), and have only completed, on average, an 8th grade education. The majority are not able to speak English well. They are generally paid very poorly and live and work in risky conditions (National Center

for Farmworker Health, Inc., 2012). For instance, farmworkers in North Carolina work long hours and are at a high risk for heat stress and pesticide poisoning. Furthermore, their living conditions present public health issues due to lack of clean water, crowded spaces, and unsanitary conditions (Farmworker Ministry Committee, 2012). A study in 2008 found that 89% of migrant labor camps in North Carolina violated at least one provision from the Migrant Housing Act of North Carolina, which sets the minimum standards of living for labor camps. Seventy eight percent of the workers surveyed in the study reported having a crowded living space (Vallejos et. al., 2012).

Although workers endure injuries and disease because of the poor conditions of their habitation and work, they often have limited access to healthcare services. A variety of factors prevent workers from receiving the care they need, including a lack of insurance coverage, transportation, limited hours of clinic operations, limited interpreter services in nearby facilities, and frequent relocation due to the search for work or change of season (Farmworker Ministry Committee, 2012). Temporary migrant workers are ineligible for Medicaid and public benefits (Guild, no date). Migrant farmworkers with H2-A visas receive workers' compensation if injured on the job, but are not typically provided with employer sponsored health insurance plans. Growers are not required to provide workers compensation to workers that do not have H2-A visas unless they employ 10 full time, year-long workers, so others go without workers compensation and employer based health insurance. The Affordable Care Act requires most people, including legally residing migrants (those who are citizens or H2 Temporary Guest Workers) to have health insurance coverage or pay a penalty (unless they otherwise meet an exemption) (Guild, no date). These individuals can purchase health insurance coverage through the marketplace and are offered subsides below 100% of the Federal Poverty Line. However, due to the population-specific living and working conditions, barriers to enrolling this population in the ACA may be different than barriers to enrolling the North Carolina immigrant population at large.

Refugees

The Office of Refugee Resettlement (ORR) settles several thousand refugees and asylees in North Carolina each year. In recent years, the majority came from Bhutan, Burma, and Iraq (Martin & Yankay, 2012). According to U.S. immigration law, refugee status can be granted to people who are outside their country of origin and have been persecuted or fear they will be persecuted because of their race, religion, nationality, and/or membership in a specific social group or identify with a particular political ideology. Asylum status is granted to those who meet the U.S. government definition of refugee, are already in the U.S., and are seeking admission at an entry point. This study will refer to people who have either refugee status, asylum status, or are asylum seeking, as refugees, as there is little practical difference between the statuses once they are obtained.

Refugees often come from circumstances where there was poor access to adequate healthcare (Norredam et.al., 2006). Additionally, many have experienced significant trauma prior to arrival. In addition to a prevalence of physical health problems as the result of torture and trauma (i.e. fractures, head injuries and epilepsy, hearing and visual impairment, and consequences of sexual violence), it is common that refugees experience psychiatric stress (Burnett & Peel, 2001) (Asgary & Segar, 2011). Furthermore, it has been shown that there are higher rates of infectious diseases and dental and nutritional problems among these populations (Ouimet, Munoz, Narasiah et. al., 2008) (Gavagan, Brodyaga, 1998).

Refugees are less likely to utilize healthcare and social services than other immigrant groups. This is due to internal barriers, such as mental illness, mistrust, and perceived discrimination; structural barriers, including affordability, limited services, poor cultural competency among accessible services; and resettlement challenges like shelter, food, and employment security. Barriers in navigating a complex health system and inadequate community support can also inhibit refugees from seeking the care that they need (Asgary & Segar, 2011).

Upon arrival, refugees can receive healthcare coverage through Refugee Medical Assistance, which provides 8 months of coverage under the federal Immigration and Naturalization Act through Medicaid. After 8 months have passed, many refugees lose healthcare coverage because they may not work for employers that offer affordable insurance and do not meet the requirements needed to maintain their Medicaid eligibility (U.S. Department of Health and Human Services, 2013). The Affordable Care Act extends the same opportunities for obtaining healthcare coverage to refugees as it does to citizens (Refugee Health Technical Assistance Center, 2012).

The Affordable Care Act and the Expansion of Coverage

The Affordable Care Act (ACA) is one of the most significant overhauls of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The ACA generally focuses on expanding access to healthcare services through broadening health insurance coverage, increasing safety net capacity, and placing more focus on the health professional workforce; Furthermore, it seeks to improve population health through increased investments in public health and prevention; enhance the quality of care by defining, measuring, and reporting, and paying for quality; and reduce the rate of increase in healthcare costs (Silberman, 2014).

The Expansion of Coverage: Who

The ACA expands the population that can access health insurance and the manner that they obtain it. Prior to the first open enrollment period (October 1, 2013 – March 31, 2014) there were approximately 47 million nonelderly, uninsured Americans (18% of the nonelderly population).[a] At full implementation of the ACA, had all states chosen to expand Medicaid, it was predicted that the uninsured rate would fall by almost 50%, reducing the number of uninsured by over 23 million (Kenney et. al., 2013). In 2013, 48% of the U.S. population had employer sponsored insurance, about 18% had public insurance, and only about 6% had private, non-group insurance (The Kaiser Family Foundation, 2013,2).

One way in which the ACA will change how Americans access their healthcare insurance is by requiring businesses to offer insurance to their employees. The number of uninsured is closely linked to the unemployment rate in the U.S. Further, most uninsured workers are employees of a company that does not offer health insurance, are ineligible for their employer's insurance, or cannot afford their employer's insurance premiums. Firms with a high percentage of low-wage workers are less likely to offer coverage than firms with fewer low-wage workers, and a consistent disparity exists across industry groups between white and blue collar job access to health insurance (The Kaiser Family Foundation, 2013). By 2016, the ACA will require that businesses with 50 or more full-time equivalent (FTE) employees offer insurance to their workers. Failure to comply with this regulation will result in an Employer Shared Responsibility Payment in their federal tax

[a] Most people over the age of 65 are insured by Medicare.

return. Very small businesses with 25 or fewer employees and average annual wages of $50,000 or less are offered a tax credit to assist the business in providing coverage. By 2016, all employers with less than 100 FTEs will be able to shop for insurance for their employees in the Small Business Health Options Program (SHOP) Marketplace.

Many uninsured individuals will still be unable to access group insurance through their employer if they work for a small business that is not subject to the requirement (as many of the uninsured do) or if the premiums of the insurance that their employer offers is considered unaffordable (more than 9.5% of their income). The ACA also sought to extend public insurance as well as make individual, private insurance much more affordable. Upon the creation of the ACA, it was envisioned that all states would expand Medicaid coverage to individuals who have an income below 138% of the federal poverty line (for continental U.S. 138% FPL=$15,856 for an individual, $32,499 in four person household in 2014). Individuals that have an income between 100%-400% of the FPL are able to shop for insurance in the individual marketplace and will be eligible for premium tax credits, which are offered on a sliding scale basis to limit the cost of a premium if they are not eligible for publicly-subsidized health insurance (Medicaid, CHIP, Medicare) and they are not eligible for affordable employer sponsored insurance. In addition, individuals with an income between 100%-250% of the FPL will be offered cost-sharing subsidies to limit out-of-pocket expenses.

In discordance with the original vision of the ACA, on June 28, 2012, the Supreme Court ruled in the case *National Federation of Independent Business v. Sebelius*, 567 US ___ (2012), 132 S.Ct 2566 that states cannot be required to expand Medicaid or be threatened by the loss of Medicaid funding due to its decision. By March of 2014, 19 states had decided not to expand and five were in open debate (Garfield et. al., 2014). Individuals that reside in those states who are not eligible for Medicaid and are below 100% of the FPL fall into an insurance gap. They are not eligible for subsidies and, therefore, likely cannot afford to purchase private insurance at full price. In many of these states, Medicaid eligibility has stringent qualification rules and does not cover all adults with incomes up to 100% of the FPL. For instance, in North Carolina, individual adults without children are only eligible if their incomes are below 45% of the FPL (Garfield et. al., 2014). Due to North Carolina's decision to forgo expansion, approximately 318,710 individuals will fall into the coverage gap (Garfield et. al., 2014).

The Implications of the Expansion of Coverage: Health Services

In addition to increasing the numbers of people who have access to affordable insurance coverage, the ACA also created a standard set of "essential health benefits" that must be included in a qualified health plan offered in the non-group or small group market. The essential benefits include services in 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (Healthcare.gov, 2014,2). Preventive care, immunizations, and medical screenings must be covered with no cost sharing (e.g. co-payments, co-insurance, or deductibles). These efforts standardize covered services across plans and place emphasis on preventive care, primary care, and mental health services needed to maintain the health of the public.

Remaining Uninsured

Lack of sufficient healthcare insurance coverage is not only a threat to personal health and risks the health of the public; it also creates significant personal financial vulnerability and a financial burden for the public. When an uninsured consumer seeks health services, they are frequently charged a much higher rate than the rate for a third party payer (Anderson, 2007). If the procedure is not an emergency, the uninsured can be turned away or asked to pay immediately for their service, participate in the provider's payment plan, or pay with credit cards. In general, the uninsured pay a much higher proportion of their care out-of-pocket than a person with an insurance plan (The Kaiser Family Foundation, 2013). Almost one-quarter of uninsured, nonelderly individuals have medical bills that they are unable to pay at all (Cohen, 2012). Unpaid bills go on to affect other aspects of a person's life, such as their ability to get credit. Furthermore, an uninsured consumer is at a higher risk of falling into medical bankruptcy than someone with health insurance. About half of all bankruptcies in the United States can be attributed, at least in part, to medical debts (Himmelstein, et. al., 2009). The uninsured are more likely to be "very worried about not being able to afford healthcare services" and more likely to put-off or postpone needed healthcare, therefore risking the state of their overall health (The Kaiser Family Foundation, 2013,3). The burden to pay for the uncompensated costs of the uninsured falls on the provider, federal, state, and local funds, and the public at large through cost shifting (The Kaiser Family Foundation, 2013).

Even though the ACA seeks to vastly expand coverage, a large number of people are likely to remain uninsured. For example, undocumented immigrants are ineligible to purchase coverage with subsidies or tax credits in the Marketplace, and as noted earlier, are not eligible for Medicaid or CHIP. Others may find that health insurance coverage is still unaffordable, such as adults with incomes below 100% FPL who live in states that did not expand Medicaid (excluding immigrant groups that are offered subsidies below 100% FPL). Some people are exempt from the insurance mandate (e.g. not subject to the tax penalties), including those for whom the lowest cost plan exceeds 8% of their income; people who would have been eligible for Medicaid if their state expanded coverage, but who live in a state that chose not to expand Medicaid; people who participate in a healthcare sharing ministry; and those who are currently incarcerated. People who do not qualify for an exemption and who chose not to get covered will be required to pay a tax penalty that increases each year. In 2014, the penalty equaled $95 dollars per adult and $47.50 per child or 1% of their taxable income (whichever is greater) and will increase each year until 2016, at which time it will be $695 per adult, $347 per child, or 2.5% of yearly household income (whichever is greater) (Patient Protection and Affordable Care Act, 2010). Although everyone will continue to be able to access emergency services under provisions in the 1986 Emergency Medical Treatment and Active Labor Act, the health risks and the financial burden associated with remaining uninsured are likely to persist. Due to the increasing tax penalty and the associated risks of remaining uninsured, it is important for individuals to take advantage of the ACA's expansion of insurance coverage and for society to value and prioritize the enrollment of all uninsured individuals.

Enrollment in ACA Marketplace Insurance

Studies have shown that many of the uninsured want help understanding their health insurance options before enrolling (Enroll America, 2014). The ACA requires state or federally facilitated exchanges to contract with "navigator" organizations that will help people understand their health

insurance options and enroll into coverage (Patient Protection and Affordable Care Act, 2010). In addition, other types of organizations or individuals can help people with the enrollment process. There are four primary types of Assister Programs which operate in North Carolina and are described briefly below (Pollitz & Tolbert, 2014).

- Navigator Assister Programs have contracts with the U.S. Centers for Medicare and Medicaid Services (CMS) and provide free outreach and enrollment assistance services. In addition, they are required to educate the public and complete outreach efforts, help consumers apply for subsidies, facilitate enrollment in qualified health plans, and provide fair and impartial information about the insurance plans. Navigators complete a federal training program, which takes 20-30 hours online.
- Certified Application Counselor (CAC) organizations do not receive direct funding from the Marketplace, but also provide assistance to consumers for free. CACs are not required to engage in outreach, although many do, and primarily focus on direct enrollment assistance. CAC organizations are registered with the Marketplace and their assisters go through a 5-10 hour online federal training.
- Federally Qualified Health Centers (FQHC) are Assister programs that are operated by health centers. They receive federal funding to provide primary care services and generally have a mission to treat anyone, regardless of their ability to pay. Because they serve primarily low income and uninsured patients, they are funded by the Health Resources and Services Administration to provide enrollment and education services. FQHCs are required to complete the 5-10 hour online training for Certified Application Counselors.
- Agents and Brokers are paid by insurance companies to provide professional assistance in educating consumers about Marketplaces and insurance affordability programs. Further, they provide in-person assistance during the marketplace application process. They played an important role in assistance with helping consumers enroll in the Marketplace.

The U.S. Department of Health and Human Services has awarded organizations in North Carolina over $3,000,000 in 2013 and $2,800,000 dollars in 2014 for providing navigator services, including outreach and education efforts (Navigator Curriculum, 2014). In addition, during the fiscal 2013 year, the Health Resources and Services Administration awarded over $4,000,000 to FQHC's in North Carolina (HRSA, 2013). Nationwide, most assister organizations were funded by private sources or by federal safety net clinic programs (Pollitz & Tolbert, 2014). These organizations have trained volunteers and employees to assist consumers in any way possible, promote enrollment, and educate the public.

Consumer Assistance Programs (CAPs) also assist by answering questions about eligibility and enrollment and resolving complaints. Navigators and other Marketplace assisters are required to refer consumers to CAPs for post-enrollment assistance. North Carolina's CAP is run by the Health Insurance Smart NC, a program within the NC Department of Insurance.

Private health insurance companies that participate in the marketplace must offer health plans with two different actuarial values: 70% (called a "silver" plan), and 80% (called a "gold" plan). They also have the option of offering a bronze plan (60% actuarial value) and a platinum plan (90% actuarial value). Each type of plan differs in the division of out-of-pocket costs and premiums. For example, bronze plans tend to have low monthly premiums but high deductibles and cover, on average, approximately 60% of healthcare costs, while platinum plans have lower

out-of-pocket costs but the highest premiums, and are designed to cover 90% of average healthcare costs (Addendum, 2014). During the first open enrollment period, most North Carolinians chose silver plans, which offer cost sharing reductions based on income eligibility.

Consumers can apply or change health insurance plans during open enrollment periods. Open Enrollment Period 1 ran from October 15, 2013 through April 19, 2014. Open Enrollment Period 2 ran from November 15, 2014 through February 15, 2015. Consumers that are part of a federally recognized tribe or an Alaska Native Shareholder can enroll at any point during the year. Any other consumer can apply during the Special Enrollment Period (SEP), which covers the rest of the year, if they have undergone a "qualifying life event" and apply within 60 days of the event during the year. Qualifying life events include a change of residence, gaining citizenship, release from incarceration, marriage or divorce, involuntary loss of health coverage, or birth or adoption of a child. Over 11 million Americans were enrolled in a health plan through a marketplace by the end of Open Enrollment Period 2 (February 15, 2015). More than a half a million North Carolinians (559,473) selected a plan during this time period (U.S. Department of Health and Human Services, 2015).

The Kaiser Family Foundation produced a report after surveying health insurance marketplace assister programs after Open Enrollment 1 that discussed pertinent findings that aid in understanding ACA enrollment (Pollitz & Tolbert, 2014). Most assister programs served specific geographic areas or targeted population groups and rely on a small staff (71% have 5 FTEs or fewer). CAC Programs are more likely to rely on volunteers. Enrollment assistance is time-intensive; more than 60% of programs reported that helping a consumer required, on average, 1-2 hours per person and 23% reported an average time that exceeded 2 hours. The primary reasons that consumers sought help from assisters was due to a limited understanding of the ACA, help understanding plan choices, a lack of confidence to apply alone, and technical difficulties in applying by themselves. Assister programs reported after Open Enrollment 1 that consumers had difficulties with website outages, subsidy eligibility rules based on tax code rules, and communication issues between the Marketplace and Medicaid agencies. Most of the consumers that received assistance were uninsured and had limited health insurance literacy. Eighty-nine percent of Assister Programs reported that consumers had questions that weren't easily answered (Pollitz & Tolbert, 2014).

While Assister Programs reported numerous challenges that affected the general population, such as website problems, income verification, and difficulty understanding plan choices, there were specific problems unique to immigrant populations. For example, Assister Programs reported that language needs could not always be met, problems verifying immigration status, and issues with identity verification. Immigration issues often presented particular difficulties, such as data matching problems that prevented the government from identifying the information of naturalized citizens, leading to cases where immigrants had to sign up during the SEP.

The literature suggests that immigrants are more likely to have issues enrolling in the ACA, in North Carolina and nationally, due to eligibility and access barriers, misinformation, a lack of understanding, trust and an assortment of other factors, including those mentioned in the previous paragraph. Furthermore, migrant workers that are eligible for the ACA or non-immigrant refugees may be confronted with additional barriers. It is important for assisters to be aware of the issues that confront these populations in regards to obtaining health insurance through the marketplace.

To be successful in enrolling and educating as many consumers as possible, it is important that assisters share ways in which they have mitigated the barriers that these populations face.

METHODOLOGY

Research Design

The researcher conducted a multiple case study to gain a better understanding of the factors that prevent and facilitate assisters in enrolling the Latino immigrant population, temporary migrant workers with H2-A or H2-B visas, and refugees in a qualified health plan through the marketplace in North Carolina. As defined by Yin, case studies allow for an investigation of "a contemporary phenomenon within its real-life context" (1994. p. 13). Each case study was "bounded" by the three populations mentioned above. (Merriam, 2009). Following Yin's framework (1994), this study used a holistic qualitative design to examine the nature of the barriers that assisters experience in enrolling the specific population that they work with, and how the assisters attempt to overcome challenges that they experience. Then, the researcher used themes from the within-case analyses to compare and contrast themes that were specific and generalizable between each population.

Research methods and data sources

To gather the data for each case study, the researcher conducted telephone interviews using a semi-structured interview guide that asked about the challenges that they experienced in enrolling a specific population and the strategies that they used to overcome the barriers. According to Merriam, qualitative research is derived from the philosophy of phenomenology which focuses on the experience itself and how experiencing something is transformed into consciousness. In other words, phenomenology is "a study of people's conscious experience of their life-world" (2009, p. 25).

Assisters who work directly with these populations in helping to facilitate enrollment are the most familiar with issues that foreign-born populations confront during their Marketplace application, and how best to address them. The assister perspective is an excellent resource for other assisters conducting enrollment appointments and for policy makers who should understand how the ACA and the Marketplace directly impact these populations. A total of 8 interviews were conducted with assisters from 7 different organizations. Information about the migrant farmworker population was supplemented by a webinar created by North Carolina Community Health Center Association called "Helping H-2A Farmworkers Enroll: Practical Tips for Connecting with Workers and Helping them Enroll" which was released on Thursday March 26, 2015.

Participants and Sampling Methods

The researcher interviewed assisters who had extensive experience in helping enroll the Latino immigrant population at large, or one of the specific communities of migrant workers or refugees. "Extensive experience" was based on the number of consumers consulted in the targeted population. Stratified purposeful sampling was used to identify respondents by the types of immigrant populations they serve. The researcher also based the chosen respondents on geographic areas with high populations of Latino immigrants, temporary migrant workers, or refugees. Table 2 displays the North Carolina counties with the highest populations of each case.

Table 2. High Case Population Type per County

Counties with highest proportion of noncitizen immigrants	Counties with highest proportion of migrant workers	Counties with highest proportion of refugees/asyllees
Mecklenburg	Nash	Guilford
Wake	Harnett	Mecklenburg
Guilford	Sampson	Wake
Cumberland	Duplin	Durham
Union	Wilson	Craven
Orange	Wayne	New Hanover
Johnston	Johnston	Orange

Data Retrieved from ACS-5 Year Estimates, Employment Security Commission, and NC Division of Social Services

Participants came from a variety of organizational types and positions. All contacts were made by email and phone to set up the interview. Everyone who replied with interest was interviewed as long as they personally provided direct enrollment assistance to the target population.

Instrument: Interview Guide

Interviews were utilized to "obtain a special kind of information," (Merriam, 2009, p. 88). Identifying the barriers and facilitators to enrolling foreign-born populations in the Affordable Care Act would not be possible through observation. The interview guide prompted assisters to provide the researcher with data about their perceptions of the facilitators and barriers that they encounter when helping a consumer of a certain population and how they attempt to mitigate the challenges that they face.

The semi-structured interview guide asked study participants about their experiences with outreach/education (where the assister reaches out to the population to spread general information about insurance and the advantages of being covered), marketing for their assistance services, direct consumer assistance to help people apply for and select a plan in the marketplace, and follow-up efforts. Respondents were asked both about barriers and facilitators they encountered working with Latino (referring to Latino immigrants), migrant farmworkers (specifically H-2A visa holders), or refugee populations. The guide is provided in Appendix B, and explained in more detail in the findings section of this study.

Data Analysis Methods

Data from the interviews were coded to analyze themes within each population case study in order to understand the assisters' perceptions of the barriers and facilitators that their target population faces in enrollment (Merriam, 2009). The researcher used a matrix to conduct an across-case analysis (Miles and Huberman, 1994) to determine how barriers and strategies may overlap or differ between population cases. This was useful to identify strategies that have only been implemented to assist one specific population, but may also be advantageous for assisters helping other populations.

Ethical Considerations

Data collected by interviews is data provided directly by people and can therefore impact the participant in sometimes negative ways. Maintaining confidentiality was an extremely important prerogative during the data collection and analysis process. All data was kept in password protected files and not released or viewed beyond the researcher herself. Ethical considerations are particularly important for this study because interview participants spoke about their job and challenges they face while doing their work. During data collection and analysis, personally identifiable information was contained to one file and their interview information was coded on any other file used. Furthermore, any contact made (by email or phone) was later deleted from the phone/email account. To minimize the risk of experiencing a loss of professional standing or reputation, any data that could potentially hinder the participant was left out of the analysis.

The Institutional Review Board at the University of North Carolina at Chapel reviewed and approved the research methodology used.

FINDINGS

Qualitative Analysis

Qualitative data were compared within each case study population (Latino population, migrant farmworker population, and refugee population) and then across groups to understand the barriers to enrolling consumers and how assisters may mitigate these barriers to ensure successful enrollment. By comparing the responses provided by the key informants in each case, we can gain a better understanding of whether certain strategies are more effective in handling situations that occur in one target population but not others.

Interviews were divided into 6 sections. First, respondents were asked to describe their organization and target population. Then assisters were asked about the following four areas to uncover barriers and facilitators to enrollment: Marketing, Outreach, and Education; The Enrollment Process; After the Appointment/ Follow-up and Education; and Keys to Success/Recommendations). Within each of these areas, key informants emphasized varying topics depending on their target population. Overall, Marketing and Outreach varied the most significantly between the three targeted populations. Respondents incorporated education into various steps of the enrollment process. Below are the different themes that emerged from the interviews.

Assisting the Latino Population

In-person assisters interviewed were very experienced in serving Latino populations. The respondents worked within businesses that already serve Latino clients in other services (legal and clinical). Both of the key informants worked in organizations that were provided funding for their ACA efforts. Further, because their organizations had been involved since Open Enrollment 1, they were heavily involved in both local and statewide coalitions of organizations that do ACA work.

Both assisters stressed that access to medical services, namely the ability to adequately navigate the U.S. health system, improves as Latinos spend more time in the country. However, one respondent named other barriers that inhibit consumers within this population from receiving necessary medical care, including language, culture of using medical services, lack of health literacy, transportation, and scheduling issues. Both assisters mentioned that Latino consumers typically have minimal understanding of health insurance or of the Affordable Care Act. They mentioned a high level of confusion over why it is expensive and complicated to understand. In general, both assisters noted that Latino consumers fear the tax penalty that results in failure to enroll in health insurance and more broadly fear personal failure of complying with the law. However, it was also stressed that families with mixed immigration statuses are generally more fearful of the process, because of concerns about their immigration status and applying for public services. One assister who was interviewed for her work with the refugee population, but also had a depth of experience serving the Latino population, mentioned that there is also a need to educate those who may not be eligible for assistance through the ACA marketplace. These individuals often had many questions about the law and how it might affect them, but had difficulty finding answers to their questions. Further, one of the two assisters interviewed in this case suggested that all assisters should use every opportunity to educate clients about the ACA, even consumers who are determined to be ineligible because they can spread information about the ACA to their

community through word-of-mouth and because they may become eligible if they become legal permanent residents.

Marketing and Outreach

Unlike respondents who worked for refugee and migrant farmworker populations, respondents that targeted the Latino population noted that connecting with radio stations was one of the most effective manners to reach consumers. Respondents established relationships with local Latino radio stations that enabled them to provide informative commercials and regular question/answer segments in which listeners could call in to ask the assister their questions. Both assisters mentioned that these radio segments were a primary reason that many of their clients sought out enrollment assistance services. In relation to the radio, one interviewer mentioned the importance of timing heavy advertising to important deadlines and highlighting the potential tax penalty for failure to enroll as two successful tactics to reach the Latino population:

> *I often find that it has to do with timing because when it's the beginning of open enrollment or near the end, regardless [of immigration status] people have their ears tuned to this…It could be in part because the general media covers it more and there is a bigger push, not just from our agencies but maybe health insurance companies, so it is just out there more… We found that we got flow in general appointments and attendance to our outreach events kind of in the middle, like right after that first deadline passed. We found [that] …. a lot of Latinos thought that the deadline was December 15, because a lot of messaging was 'sign up by December 15 so that you have your coverage by January 1' so a lot of people thought that was the deadline.*

Another practice that was highlighted by one respondent was being creative to target a 'lively community' and population. Specifically, his organization used ice cream trucks to capture the attention of the Latino community during the off season of enrollment. The ACA educators created a fun ACA educational event by having consumers spin a wheel that included ACA and Marketplace related themes. The consumers had to spin the wheel and learn about the ACA before he or she was able to purchase ice cream. This respondent later stressed this message when he emphasized being creative, having fun, and being yourself as lessons he learned about successful marketing and outreach efforts.

Lastly, one respondent mentioned that word-of-mouth in the Latino population is the most valued manner of spreading pertinent information about the ACA and gaining new clients to assist:

> *I find that half of my clients are related to each other or know each other. It could be a week's worth of my clients are the friends or relatives of one initial person that I helped, and his coworkers… In that sense, it is good to build that trust and that rapport with Latino clients because they really do spread the message. And I think that could be applied to really all immigrant populations.*

Helping People Enroll

Respondents held ACA enrollment services both by appointment and through enrollment events. They offered enrollment services at different times and locations. The manner in which they held their appointments differed based on the organization in which they worked. One respondent held appointments within their health clinic and guided current patients to their services

via signs, arrows, and within clinic advertising (in Spanish and English). The other traveled to a variety of community organizations to hold appointments, attempting to eliminate or lessen barriers that often led to cancelations such as conflicting work schedules, lack of transportation, and family situations/childcare.

Both respondents said that the minimum time they spent with consumers was two appointments. The appointments could last 1-2 hours, depending on the needs of the specific consumer, how prepared they were for the appointment (e.g. whether they had all necessary documents, knew the information needed to complete the application, allotted appropriate amount of time for appointment), the size of their family, and any complications of the specific case. One assister used the first appointment to work towards completing the application and used the second appointment to tie up loose ends in the application, choose a plan and educate about next steps and specific insurance plan that the consumer chose. The other assister used the first appointment specifically for education and determining potential eligibility, but waited for the second appointment to fill out the application and sign up for the plan with the consumer:

> *Believe it or not, it is more convenient [to use two, separate appointments]. It is a lot [of information] to give [in one appointment]. It is too much, especially when health insurance is brand new. They are asking all of these questions and for recommendations. And you are also dealing with other issues. And when they come back they ask for you and for your people to address them by name, and how they are doing. We have circumstances where they come 4-5 times, because of their cases and we still treat them with the same quality of care. If we know we don't have an appointment following, we will go longer than one hour, but we try to stick to one hour.*

This statement demonstrates that not only do multiple appointments allow consumers to digest complicated and abundant information and the time to make the right decision, but they also aid in the establishment of a trusting relationship between the consumer and the assister. In addition, scheduling multiple appointments may create more efficiency by enabling the assister to maintain time blocks and not go over time with one appointment if both parties know a follow-up appointment will occur soon.

Both respondents spoke Spanish fluently and provided all documents in Spanish. In addition, it was mentioned that it is valuable to use other community organizations to better understand the Latino population that the organization serves and to share appropriate language materials and tools for ACA enrollment. Specifically, simple and highly visual tools that do not go higher than 5th grade reading levels should be utilized when possible to simplify the complicated process.

While respondents mentioned that, in some cases, the Latino culture may not prioritize the use of Western medical services in the same manner that other populations do, understanding the expenses of medical services is a huge incentive for them to obtain health insurance. (An assister who serves the migrant farmworker population also mentioned this theme, specifically that seeing someone they know who needed medical services in the U.S. was a motivator for them to obtain insurance.) Both assisters mentioned that Latino immigrants have more interest in the ACA than the general population and want to be compliant with the law, perhaps as a part of acculturation. Furthermore, they were more likely to value the one-to-one interaction with the assister and building trust and a relationship was a significant part of enrolling Latino consumers.

The Hispanic community loves to have that one-on-one interaction with someone and have that sensation, that trustworthy sensation, that someone is helping them out. That never will be satisfied by computer or even by phone. They will always be looking for that interaction one-on-one.

Building this trust goes beyond the appointments and face-to-face interaction; it later becomes essential during follow up. It was important to both respondents that the consumers felt comfortable enough to call back with any question that they had about their insurance plan. Furthermore, both respondents had practices of calling all consumers after they had chosen a plan in order to reach out to answer questions.

It is worth noting that assisters who targeted the Latino community had the best idea of their population's satisfaction level of the insurance they chose. Respondents got the overall impression that consumers who did not need medical services in the past year either felt neutral towards the plan that they chose or dissatisfied in general for having to pay for insurance. Consumers who did utilize medical insurance and purchased a bronze plan were typically the most dissatisfied, because they felt that their insurance did not adequately cover their medical costs. Conversely, many that chose a silver plan during OE2 and utilized medical services expressed that it worked in saving them money.

Key Points

At the end of each interview, respondents had the opportunity to voice what they considered to be the keys to success in working with their target population. The first respondent emphasized partnering with organizations in the community that already serve the local Latino populations and meeting community members in places that they already go to, facilitating the interaction for consumers. Furthermore, according to this respondent, it is important to collaborate with others so as to not "reinvent the wheel". In contrast, the second respondent emphasized self-awareness. The assister should feel capable in delivering the message, even if they are not 100% bilingual. This feeling of confidence will make consumers feel more comfortable, which makes them more likely to approach the assister for help.

Assisting the Migrant Farmworker Population:

Key informant responders who assisted the migrant farmworker population worked in FQHCs that provided outreach and clinical services to this population. All three began providing ACA focused services during the first Open Enrollment period.

Because the respondents were all from health service delivery organizations, they were very familiar with the way that farmworkers typically access medical services. Farmworkers have variable availability of transportation, time off, and existing networks of care in their communities. In addition, the growers who hire the farmworkers have inconsistent expectations and resources. Some communities' healthcare organizations provide transportation and/or bring physicians to the farms so that farmworkers can receive the care they need, while farmworkers in other places are unable to access the medical care they need because of lack of transportation or lack of existing infrastructure to serve their needs.

Respondents mentioned that many farmworkers have only a vague understanding of the concept of health insurance and its value. As it was mentioned before, it was best understood when a farmworker knew someone who got sick and required medical services in the U.S. This

experience helped teach them about the high costs within the U.S. medical system and the risks of going without insurance. Otherwise, farmworkers typically tried to hold off on receiving medical services until they return to their home country. Farmworkers often have mixed reactions about signing up, once the ACA has been fully explained to them. Two of three respondents noted how informal leaders sway the opinion and impact the emotion of all the workers in each farm camp. They explained that interpersonal relationships among farmworkers can therefore affect the assisters' ability to engage entire camps in ACA enrollment.

> *So usually, if we have one person in one camp or two people that are very interested maybe they can get the rest interested but when one has a negative feeling about it and just doesn't want to do it and is a leader, the rest of the group will follow it, and that's very, very common.*

Like the general Latino population, farmworkers frequently asked assisters "What if I choose not to enroll in the Affordable Care Act?" They wanted to understand how the law would negatively impact them and their ability to obtain their visas when they return in upcoming years. Assisters noted that one advantage of working with this population is that they are eager to comply with the law because they are worried about their ability to continue working in the U.S. if they do not comply.

Marketing and Outreach

The vast majority of marketing, outreach, education, and enrollment occurred at the farmworker camps and not by appointment in an office or clinic. This means that assisters went directly to where the farmworkers reside to build relationships, educate farmworkers about the ACA, and hold enrollment events. They also worked with partner organizations that had previously built and established relationships with the farmworker populations for help with outreach. One respondent mentioned that working with the grower (the boss of the farmworker) was also an important way to reach this population, but can be very variable in terms of reciprocated support.

All of the respondents noted that the best way to reach this population was going to the farms where the farmworkers reside. Building trust was also heavily emphasized by all assisters. This was supported by the recommendation that assisters understand the culture and lives of the farmworker populations. One respondent briefly mentioned that advertising in community businesses where farmworkers frequent is another way to spread information (such as contact information of the assister organizations).

One important way in which this population differed from the other two populations was that they lacked community support and networks that other populations have and use to share information. Farmworkers are typically very secluded and have limited ability to share knowledge and information. This made going to the farms even more important because there are very few resources other than the assister that farmworkers can use to learn about the Affordable Care Act.

Helping Consumers Enroll

The most significant hurdle that assisters faced when enrolling farmworkers was the knowledge barrier. On average, respondents noted that completing the application over the phone took about an hour. But before the phone call was made, assisters spent many additional hours educating farmworkers at the camp, answering questions, and holding personal appointments with each consumer to further teach about plans. It was emphasized by all respondents that fliers are

ineffective in spreading this information at the camp. Assisters that were interviewed go to the camps with examples and visual explanations to facilitate their explanation about how obtaining insurance may be helpful to consumers in this population. This often took multiple visits to the camp prior to beginning the application. When the application is completed, it was usually during the special enrollment period, by phone, and on the weekend when the workers have days off.

In addition to the regular challenges of finding times when it is convenient to work with the consumers, assisters who work with migrant farmworker communities had to do all the education and enrollment activities within the 60 days of when they first arrive in the state (their special enrollment period). Most workers arrive to North Carolina around April/ June and leave in the fall. When they file their taxes, they must show that they were enrolled in insurance coverage except during periods of transition, which exempts them from the penalty for a period of 60 days. However, assisters emphasized that it can be difficult to enroll farmworkers during that special enrollment period because they may not have received income documentation or their social security card (although they can still apply as long as they have their number by the time they file their taxes). (Webinar, NCCHCA 2015).

Some aspects of the application that may seem simple when working with other populations can be complicated for the farmworker population. Sometimes they do not have their own mailing address to list on their application to receive notifications from the marketplace or they may use the address of the grower that they work for. According to assisters, during the pre-enrollment visits they asked farmworkers to consider what they would use as their mailing address.

Applications in this population were completed over the phone for a number of reasons. Most of these consumers did not have access to computer technology that enabled them to fill out or check their application online. While most do not have computers, many do have phones (often paid per minute). Assisters typically completed the application using their own phones rather than the farmworkers', as an effort to save the farmworkers money. Two assisters mentioned that before the application is completed, consumers were educated and familiar enough with insurance and their options to have a very good idea what insurance they would choose so they do not make a quick decision over the phone. Applying over the phone allows consumers to bypass the barrier that literacy may have created in the online or written application. Conversely, it was mentioned by two respondents that shyness sometimes prevented consumers from being eager to call the marketplace to complete their application and have their questions answered. If the assister used a computer to complete the application, it was mentioned by assisters in one organization that it is best to stop at the identity verification portion and complete that section over the telephone because the verification can be done more simply using a marketplace assistant than online (webinar NCCHCA, 2015).

Respondents noted that they provided a higher level of assistance to the farmworker population after they chose their plan than was typical with the other two populations. For example, respondents not only explained exactly what doctors are in and out-of-network and costs of utilizing specific services that the consumer needs, but they also provided special tools to help the farmworkers continue their insurance plan. For instance, they provided the number of the insurance company support line and step-by-step instructions for what to do over the phone and what extension numbers must be pressed. Furthermore, if needed, assisters provided explanations of when and how to fill out money orders and sometimes filled out the order with the consumer or provided templates and explained where to send them so that the premiums would be paid,

provided an envelope with the address already written, and even a ride to send in the payments. Assisters were the primary source of information for the farmworkers so they were very proactive in helping meet the needs of the hundreds of consumers that they served. Not only did they provide very detailed instructions on how to start their plan and how to use it, they also provided directions on how to cancel their plan and reminders to cancel their plan when they returned to their home country.

Key Points

One assister involved the growers to help reach the migrant farmworker population, but the other two respondents leveraged community organizations' relationships with returning farmworkers to reach the population. All respondents emphasized that going to where people congregate was an important way to spread news and quick information. As was mentioned in the Latino population case study, speaking Spanish and understanding the culture and immigration status (and how it applies to eligibility and qualification for subsidies within this population) of the client was critical to facilitate the enrollment process.

Assisting the Refugee Population

Each of the three respondents worked in non-profit organizations that served refugees in different ways. One respondent worked in an organization that directly advocated for this population and provided general refugee and immigrant assistance, another worked within a legal agency that provides free legal services to refugees (among other populations), and the third worked within an organization that coordinates care and promotes collaboration to improve health services delivery to the uninsured within their county. Two of the respondents were navigators, while the third was a certified application counselor. Respondents served fewer refugees than did the assisters who served Latinos or migrant farmworkers (the highest number of refugees served by one assister was approximately 50). Respondents reported that they reached this population by partnering with organizations that served refugees in their transition and adjustment to living in the U.S. or with organizations that refugees frequently used (i.e. churches).

Even though many refugees receive eight months of Medicaid upon arrival, many other factors create barriers in seeking proper medical care. All three respondents emphasized language as a primary barrier to refugees receiving the care that they need, despite the use of language lines. Respondents also listed transportation as a huge barrier to accessing medical services. Further, despite having eight months with Medicaid, respondents mentioned that consumers in the refugee population still have little understanding of how health insurance works. They have a difficult adjustment once their Medicaid ends and they are required to pay for health services. Assisters reported difficulty explaining the ACA because of the language barrier and concern that their explanation is not being fully understood. Similar to the general Latino immigrant population, refugees were also concerned about breaking the law and worry about how not obtaining health insurance may impact their ability to become citizens.

Marketing, Outreach, and Education

Respondents emphasized that reaching this population was most effective when assisters promoted ACA services at local businesses and organizations that refugees frequent, such as hair salons, grocery stores, and refugee owned business. Otherwise, word-of-mouth is how most information is spread throughout refugee communities. Two assisters expressed frustration that

there was not a more efficient way to spread information to many refugees at once; word of mouth takes lots of time and lots of educational and outreach efforts to other organizations in the community. Language remained a huge barrier to effective communication. Because of language barriers and the number of languages that refugees speak, it was more difficult to do mass presentations with this community than with the other targeted populations.

> *It's been really difficult to impart the importance of signing up for the Affordable Care Act… that there was a deadline that they had to sign up but and if they didn't sign up by the deadline there is possibility of being fined. At some of the places that we were doing outreach, there were still a lot of people that could have benefitted that we didn't get to, even though we went every week to some of those places. It's hard to do a general presentation, or general announcement, because not everyone understands when you do it in English and meeting with people on an individual basis takes a long time. Even to explain the Affordable Care Act and how it affects that one individual may take an hour and a half or two, it might take up the whole appointment slot….. but that's when the understanding goes up a lot, when they are able to ask questions and air their doubts and get the information that they are unsure about. But it takes a lot of resources for there to be enough assisters to sit down and do that.*

Assisters found that language barriers also made explaining the advantages of the ACA to the refugee population much more difficult. Furthermore, all respondents emphasized that explaining the ACA was complicated by refugees' previous experiences with free health coverage through Medicaid; it was difficult to explain why they now must pay for the coverage in premiums each month when they previously received insurance for free, especially when many have had no experience with health coverage, either in the US or in their home country. One assister suggested that the best way to conduct outreach and education may be through setting up informational tables rather than through general presentations. This way, initial education may be conducted through a less formal setting than an appointment, but still allow the opportunity for consumers to come by and quickly ask questions. From there, consumers could set up individual appointments to learn more and to enroll. Alternatively, it was suggested by a few assisters that education needs to be divided by language groups. Then, it becomes far less complicated to share basic information when the assister and the group of consumers are working only between two languages, rather than 5.

One respondent suggested that assisters who would like to directly target the refugee population should consider partnering with social workers in congregational services who keep track of when Medicaid eligibility ends for each refugee. This way, outreach can happen directly upon the loss of Medicaid coverage. In addition, assisters can offer enrollment services outside of Open Enrollment to refugees (as loss of Medicaid coverage is grounds for special enrollment periods). In general, one respondent felt that refugees were more connected with non-profit services in their community, compared to the other two targeted populations, which may make it easier for them to access or hear about public services that are available to them. All three respondents felt that partnering with community organizations, sharing resources, and collaborating to conduct outreach and education about the ACA was the most effective way to reach and enroll consumers of the refugee population. The success of marketing and outreach efforts depended on the willingness of community organizations to engage in a relationship with assisters to promote their services.

Helping Consumers Enroll

Transportation and language barriers remained major issues throughout every step of the enrollment process with consumers in refugee communities. All assisters suggested meeting consumers for enrollment appointments where they already go. Respondents also noted that having an interpreter present for the appointment was more valuable than the language line, although the line was the most used language resource. Two respondents ran into situations where the language line did not offer the necessary dialect. Respondents felt that communicating was easier if an interpreter was available to meet with both the consumer and the assister.

Assisters also mentioned a variety of external barriers that impact refugees' ability to obtain insurance. One of these, related to language, is that the insurance companies themselves did not offer their services or materials in the languages needed by all the refugee populations. Thus, it was more difficult for consumers in refugee communities to understand their insurance coverage or to work with the insurers when they had questions. Furthermore, many refugees lacked telephones or used phones with a limited number of minutes; it became costly to make the necessary calls and wait for the appropriate language adjustments. Moreover, many refugees had low levels of literacy, and needed assistance to navigate the health insurance enrollment process.

On the other hand, two respondents mentioned that serving the refugee population may be easier than serving consumers in other communities because they are one of the most patient of the different populations, perhaps because they are accustomed to long processes and exorbitant amounts of paperwork. Furthermore, in comparison to other immigrant groups, refugees often had the necessary paperwork and documentation, facilitating the enrollment process. Because of this, respondents who targeted the refugee population had mixed responses about how long their normal appointment was. One assister noted that it typically took a single two hour appointment with consumers to enroll them. However, two of the respondents mentioned that it takes at least 2 appointments (each ~1.5 hours), but a third or fourth appointment was common because of the language barriers and the time it took to educate about health insurance and the ACA.

Beyond the aforementioned barriers, affordability remained a factor that prevented enrollment for many refugees. Unlike other immigrants who are lawful permanent residents or hold another status that is subject to the 5 year ban in Medicaid, refugees are not eligible for the special rules for Marketplace coverage that would enable them to qualify for subsidies even if their incomes were below 100% FPL. As a result, refugees sometimes fall into the Medicaid coverage gap like other North Carolinians if they don't qualify for Medicaid but have incomes below 100% FPL.

Key Points

All three respondents suggested that assisters who reach out to the refugee population remember patience and positivity, even though it may take longer to enroll a consumer of this population. One respondent emphasized keeping a positive attitude within an arduous process.

> *Keep the positivity in the appointment. If you start to be negative about it, then the person will feel sad about the whole process too. Even if you are on hold with the marketplace for 30 minutes, and then on hold again waiting for a language line interpreter, and then there's issues with documentation verification issues or*

whatever, just keep positive and just being prepared that it can take a while, that it is going to take a while.

Overall, assisters seemed to feel like there was much more that could be done within refugee communities to educate and enroll consumers. Two assisters briefly mentioned that there were fewer community partners focusing on ACA enrollment in the refugee community compared to the Latino population or the farmworker population. It was also mentioned that refugee assistance organizations tended to focus on helping refugees secure employment rather than on addressing their health needs. Sometimes there was no one within these organizations supporting the health needs of refugees by coordinating their care and educating them about the U.S. health system. In addition, the organizations themselves were unfamiliar with the ACA and how it may apply to the refugee populations that they serve.

Shared Themes among the Three Populations

Several themes emerged during the interviews across the three case populations. Assisters mentioned numerous barriers that they faced when serving these different populations and shared strategies to mitigate the challenges they faced. In table 3, themes in the barriers mentioned are displayed along with the frequency of assisters who mentioned the theme. The third column shows the number of populations that the theme spanned. Table 4 mirrors the structure of table 3 but demonstrates the themes in practices utilized to mitigate common barriers among the three populations. Below each table, the themes are discussed briefly.

Table 3. Barriers faced in enrolling the Three Case Populations

Theme	**Number of Assisters Who Emphasized Theme**	**Populations The Theme Spanned**
No/minimal previous knowledge of health insurance	N=8	Latinos, Migrant Farmworkers, Refugees
Minimal understanding of ACA and eligibility requirements	N= 4	Latinos, Migrant Farmworkers, Refugees
Low literacy	N=6	Latinos, Migrant Farmworkers, Refugees
Limited access to technology/ reliance on telephones	N=5	Latinos, Migrant Farmworkers, Refugees
Transportation Barrier to access enrollment services	N=5	Latinos, Refugees
Scheduling barriers to access enrollment services	N=5	Latinos, Migrant Farmworkers, Refugees

Every assister interviewed felt that their target population generally had minimal previous knowledge of health insurance. Respondents who assisted the general Latino population noted that knowledge about health insurance increased with length of time in the country and increased familiarity with the US health system in general. As discussed above, two respondents who assisted the migrant farmworker population specified that consumers who are familiar with health insurance frequently have known someone who has previously needed health care in the US and

has been affected by the high costs. All respondents who worked with the refugee population mentioned that, while the refugee population is familiar with Medicaid, they are unfamiliar with privatized health insurance and frequently do not understand premiums and are shocked at the high costs of insurance.

Even though it was not mentioned with a very high frequency, assisters in all three populations expressed that the population they served had a minimal understanding of the ACA and specifically with ACA eligibility requirements. Overall, it was mentioned that there was confusion among all populations between ACA with Medicaid eligibility requirements and many people in the Latino population and migrant farmworker population thought that, because it is government run, it may not apply to their status. Respondents within each target population noted that consumers in their population often worried about how refusing to sign up for the ACA may affect their immigration status. Three assisters said undocumented immigrants specifically were concerned about their eligibility and about how not getting insurance would affect them, and seemed to have more misinformation about how filing their taxes without insurance would impact them.

Respondents that worked within each population faced low literacy levels within their population that often complicated the outreach, marketing, and educational portions of enrollment. Furthermore, access to technology was an enrollment barrier in all populations. Although it was discussed at length in the migrant farmworker findings section, respondents in all populations mentioned a reliance on telephone technology and detailed that while it is less likely for consumers within their target population to own a computer, they are likely to own a cell phone.

As previously discussed, transportation was a major barrier for respondents that targeted both the Latino population and the refugee population. Assisters that targeted the migrant farmworker population did not have as much difficulty with transportation for enrollment because they met most consumers directly at their place of work or stay. However, schedules remained a barrier in all three populations. Assisters specifically mentioned complications in schedules that included conflicts with other appointments (N=3), childcare/ family responsibilities (N=4), work schedules (all populations) (N=7), or the search for employment (N=3).

Table 4. Practices used by Assisters to Reduce Barriers to Enrollment

Theme	Number of Assisters who Emphasized Theme	Populations that the Theme Spanned
Partner with Community Organizations that Serve Population	N= 8	Latinos, Migrant Farmworkers, Refugees
Arrange Enrollment Appointments with Other Services that the consumer uses	N=6	Latinos, Migrant Farmworkers, Refugees
Speak Their Language/ Use in-person Interpreter if Possible	N=8	Latinos, Migrant Farmworkers, Refugees
Utilize Simple Tools	N=4	Latinos, Migrant Farmworkers
Individualize Insurance Plan After Enrollment	N=6	Latinos, Migrant Farmworkers, Refugees
Build Trust	N=5	Latinos, Migrant Farmworkers, Refugees

Respondents offered a variety of solutions to the barriers that they encountered. While some were specific to a particular population, other strategies were used to reach out to and work within all three populations. The findings represent what was emphasized by assisters, but is not necessarily coterminous with all that they do. Therefore, a theme that wasn't mentioned by an assister does not necessarily indicate that the practice was not a part of their work. All respondents mentioned partnering with community organizations that serve the population. Assisters utilized these relationships for support in a variety of ways, including: reaching and educating the population, understanding the population, sharing effective tools, planning enrollment events, identifying community advocates for enrollment, and providing central locations to hold appointments.

All assisters also mentioned either the utility of speaking the same language as the population that they served or the value of finding an in-person interpreter. All respondents that served the Latino population and the migrant farmworker population spoke Spanish. As discussed at length previously in the refugee findings section, assisters emphasized that finding an interpreter to participate in-person during the appointment was valuable for understanding and for cutting down the time it took to educate and enroll people. The language line was also listed as a valuable resource by many.

Assisters who targeted the Latino population and the migrant farmworker population emphasized the need to use simple tools in any educational or marketing efforts. These tools were written no higher than a 6th grade reading level to mitigate the barrier of illiteracy and explain new terms. This was also useful in helping consumers who lack health literacy to understand. Process maps, pictures, and videos were also utilized to explain health insurance and the ACA. Refugee assisters did not emphasize the simplicity of their tools.

After the appointment, six assisters discussed the importance of explaining how the consumers could use their insurance to meet their specific healthcare needs. This included helping the consumer looking for a primary care physician who is located close to the consumer's home,

providing a list of physicians that are in-network for the consumer, explaining in detail how much a medication will cost the consumer, etc. Assisters explained that taking ownership of the insurance could lead to greater consumer satisfaction with their plan because they will be able to effectively use what they purchased and will not be surprised by costs if they need to use a health service. Consumers should know about their plan but more specifically consumers should understand how their plan can meet their own needs.

Five assisters emphasized building trust with their consumers:

> *One thing that really helped me [with enrolling migrant farmworkers] was being there. Taking that phone call when they have a question, making sure they were understanding what was going on, what their next step was going to be. Being available… reaching out to them.*

The assister went on to describe how her small team was able to have huge success due to their dedication to the population and the trust that they were able to build with their clients. Building trust was very important for consumers to feel comfortable asking questions and providing personal but necessary information to assisters. It was important for consumers to be able to call back later to solve issues in their application and enroll and to successfully use the insurance that they purchased. Furthermore, creating these relationships was necessary to encourage consumers to spread the word about the ACA marketplace in their communities.

Opportunity for Growth

None of the respondents had completed an evaluation of their services. However, three respondents (in Latino and migrant farmworker communities) were thinking about conducting an evaluation this year (during special enrollment period). In addition, all assisters seemed eager to find out how they were doing and how effective their work was. If these groups complete an evaluation, it may be valuable for these organizations to share the feedback they receive to help other organizations reach and successfully enroll these populations.

DISCUSSION

As can be seen from the findings, consumers in these three populations have many complicated barriers that make it more difficult to be enrolled in ACA health coverage through the marketplace. Overall, assisters who helped the general Latino population emphasized speaking Spanish, using simple educational tools, educating at every opportunity, creativity in outreach efforts, utilizing the radio, strategically aligning marketing with deadlines, and working with partnerships. Assisters who targeted migrant farmworker population highlighted being available during abnormal work hours, putting in long hours at the camp, being detailed and comprehensive in the assistance provided, and utilizing the relationships that farmworkers already have with other outreach groups. Assisters in the refugee population focused their comments on language barriers, working with community organizations that provide services to refugees, and patience when facing complications such as long wait times, identification verification issues, difficulty finding locations for enrollment appointments, etc.

In many ways the barriers identified by respondents in their efforts to enroll Latinos, farmworkers, and refugees into health insurance coverage mirrored the complications that people face helping enroll immigrant groups in other public services such as Medicaid. For instance, immigrant groups can be difficult to reach and are often secluded from information that the general population is able to easily access. Immigrant groups often struggle with language barriers when trying to access services themselves. Many organizations that work with these groups rely on community organizations to spread information and engage the population (The Kaiser Family Foundation, 2011, 1).

The lessons identified through these interviews can assist a broad array of organizations providing in-person assistance to immigrant populations. Although respondents noted a number of ways in which outreach and enrollment of immigrant populations can be improved, they also highlighted issues that can only be resolved through policy changes to the underlying laws. Below implications of this study's findings are discussed in detail.

Implications for Practice

Work with Partner Organizations

Many respondents noted the importance of developing relationships with sister agencies that focused on ACA enrollment with the similar populations. As previously discussed, this collaboration could include sharing effective tools (i.e. glossaries that are effective for low health literate populations), sharing language resources, and graphics that explain health insurance and the ACA in a more simplistic and creative way. Being a part of a coalition or a work group where ideas were presented consistently in meetings that focus on the enrollment of the target population greatly impacted the work of respondents that target the enrollment of Latino consumers. NC Get Covered Coalition's focus on the enrollment of the Latino population led to the creation of many of these meetings and workgroups.

Besides coalitions and workgroups that are made of other assisters and organizations doing ACA related work, collaborating with agencies that do not focus on ACA enrollment, but serve the target population in another way (i.e. spiritually, search for employment etc.) enables assister organizations to build upon the preexisting relationships that have already been created in the community. This, in turn, increases the trust and collaboration between consumers and assisters. This allows assisters to reach more consumers by extending the presence of the assister

organization in the community. Educating partner organizations may be a particularly fruitful avenue for those assisters serving refugee populations, as some of the respondents noted that the partner agencies serving refugee populations were not as well versed on the ACA as other organizations with whom they worked. As indicated by the findings, community organizations are an important way to distribute information to the community they serve. North Carolina organizations should develop lists of non-profits that serve refugee communities to initiate contact, provide basic education about the ACA and refugees, and include resources for organizations to become involved or learn more about opportunities to collaborate with ACA focused organizations in their area.

In turn, community organizations can provide assisters an opportunity to learn more about the specific needs of the target population in the area where they serve so that they can tailor their services to reach more consumers. For instance, while transportation issues may not affect the Latino population everywhere, it does effect Latinos in specific counties. Thus, assisters in those counties may need to address this transportation barrier by holding enrollment services at, for example, a community partner's office, rather than in the office of the assister.

Furthermore, these community organizations may be more familiar with what tools are effective when working with the population and the appropriate readability level of the tools. For instance, they may be able to collaborate with ACA assisters to produce graphic and explicative pamphlets, or even a video, that contain basic information about the ACA and the services that the assister can provide. After testing these materials in a local setting, simple and effective tools can be shared within workgroups or coalitions, aiding in statewide coordination of enrollment.

Finally, as exemplified by findings from interviews with assisters who targeted the migrant farmworker population, engaging stakeholders can be a valuable way to facilitate enrollment. Assisters targeting this population may consider educating and engaging the grower in the process. While growers may have mixed reactions, one way to reach them is to go to the places they go such as Growers Association Meetings, local farm centers, and local stores where people congregate and talk and can spread the news (repair shops, barber shops). According to one assister, if the grower has the information they are more supportive about the process of getting their workers insured through the ACA marketplace.

Provide In-person Language Services When Possible

All respondents that focused on the Latino population and the migrant farmworker population mentioned that being able to speak Spanish was a huge facilitator to assisting these two populations, and a large part of their success as assisters. Respondents that served consumers in refugee populations repeatedly emphasized that language was a persistent barrier through the whole enrollment process. Conducting education and outreach in the refugee population in large group settings was a particular challenge because it was less likely that there was a language line available or because refugees spoke different languages (making communication with all the refugees present at the event difficult). One assister alluded to training community members to help spread information to the rest of the (same language) population. Almost like community health workers, leaders or volunteers could be trained about the ACA and how it could impact their family, friends, and community. This would be one way to spread information more quickly by word-of-mouth, which was identified in the findings as the most effective way to spread information to refugees. One assister mitigated the language barrier during the appointment by inviting in-person interpreters from the same community as the refugee consumer to participate in

the appointment. She emphasized that, although this was not perfect (primarily due to a difficulty in explaining insurance terminology to an interpreter who was not familiar with the concepts), it is preferred compared to using a language line.

Provide Follow-up Services to Consumers

Based on what assisters in all populations mentioned in interviews, maintaining contact with the consumer after the appointment is an important way to ensure that consumers understand how to use their insurance and to answer their questions. Phoning the consumer within a month after the appointment to ask about concerns was the most common practice. As previously mentioned, this phone call help build upon a relationship of trust that had been established during the appointment. Sometimes the consumers in the migrant farmworker population do not have telephones or have limited minutes so it is best for assisters to revisit farms at least once again after enrollment to ensure that everything is going well with their insurance coverage. As previously mentioned, it is important for assisters to call migrant farmworker consumers to remind them to cancel their plan when it was time to return to their home country. Furthermore, within the migrant farmworker population, assisters should utilize relationships with migrant farmworker outreach organizations to aid follow-up after the application is complete because if farmworkers let outreach workers know that they have a question pertaining to their insurance, the outreach worker can connect the farmworker back to the assister to answer the question.

To mitigate the barrier of refugees not owning telephones, it is possible that assisters targeting the refugee population could also utilize relationships with community organizations to reconnect with consumers when they have a problem with their insurance. However, one assister indicated that many community organizations that provide initial outreach to refugee populations lose contact after the refugee has been in country for an extended period of time, making consistency is an issue. So although assisters emphasized using community organizations to make contact with this population, assisters may want to utilize organizations that establish longer relationships with the members of the community to conduct follow-up or health literacy classes, such as churches.

By using some of these strategies, assisters may be able to more effectively reach and educate immigrant populations, to help them understand their options under the ACA and enroll in coverage. Of equal importance, however, is helping these populations understand the US health care system and the role that insurance plays in helping ensure access and financial coverage of needed services. Effective outreach and education can help lead to greater coverage and use of health services among immigrant populations, which not only is associated with better health, more access to healthcare services, and less economic risk for the individual, but is also broadly associated with better population health and a better economy (as discussed in the literature review).

Practices of Insurance Agencies that Offer Plans in Marketplace

Some assisters mentioned that there is not enough infrastructure in place to support the language needs of refugees, even after they have enrolled in a plan. Refugees often encounter language barriers when setting up their insurance. Similar to assisters that work with migrant farmworkers, assisters who target the refugee population should provide extra follow-up services to help the consumer understand how to use their insurance plan and know how to contact the insurance company when they encounter problems.

Insurance companies should also consider changing their practices to more effectively engage more consumers. For instance, insurance companies should provide insurance information in the preferred language of the consumer. In addition, the insurance card should have a number to call that will directly transfer them to their interpreter line, rather than the normal call service which is accessible to English and Spanish speakers.

Implications for Strategic Efforts by North Carolina Coalitions

As highlighted previously, North Carolina has been successful overall in enrollment efforts due in part to important coalitions that share information, collaborate, set goals, and strategize on how to focus enrollment efforts. For instance, prior to Open Enrollment Two, NC Get Covered Coalition focused efforts on certain populations, including the Latino population in North Carolina. This was done through a variety of ways including meetings to educate assisters and community organizations, allowing for them to share best practices in working with the Latino population, and by engaging stakeholders across North Carolina. This strategic effort to enroll the Latino population also included educational efforts about the migrant farmworker population.

The collective effort to enroll these populations was evident in the data from those two cases. Respondents that targeted the Latino population and the migrant farmworker population had productive relationships with other organizations that led to many combined efforts to reach the communities. However, data from respondents that worked in the refugee population indicated that a strategic effort across the state would be valuable to effectively target these communities. Assisters had varied support systems from their organizations and from community partnerships to enroll consumers. Furthermore, assisters reported that, prior to their efforts to educate community partners, these organizations had very little knowledge of the ACA and how it could be leveraged to help the community that they serve otherwise. Even just educating organizations that already work within these communities may be very useful in increasing enrollment. There is a huge opportunity to focus effort on aligning organizations that already serve refugee communities and organizations that are doing ACA enrollment. Many refugees can be served on a continual basis when they lose Medicaid after 8 months in the U.S. and it may be practical for assister organizations to direct their efforts towards serving this population during Special Enrollment periods.

Implications for Policy

This study identified a number of areas in which public policies could be changed to support increased enrollment of immigrant populations, especially in the migrant farmworker and the refugee populations. For the migrant farmworker population, allowing only a 60 day period after their arrival to get all of the necessary documents, learn about ACA enrollment, and complete the application is very difficult, especially when assisters and consumers must work around an arduous work schedule and limited resources and technology. Loosening this time period should be considered for this population.

Although immigrant populations face unique barriers, they also have similar barriers to other low income populations. Refugees encounter many of the same affordability barriers as the general low-income population in North Carolina and more affordability barriers than some other Latinos or migrant farmworkers who are in the country legally. Unlike some other immigrant populations, refugees are not subject to the 5-year Medicaid bar. As a result, they are not eligible for subsidies if their income is below 100% FPL (similar to citizens living in poverty but who do

not currently qualify for Medicaid). All three populations face the same "family glitch" as do other lower income families. The family glitch precludes family members from qualifying for subsidies in the marketplace if one of the family members has access to affordable employer sponsored coverage (e.g, the employee share of premiums for self-only coverage is less than 9.5% of their income). If the employer offers coverage to other family members, that employment based coverage is considered "affordable" to the family (even if the premium costs for the family would be well in excess of 9.5% of their combined income). Thus, families cannot qualify for subsidies in the marketplace if another family member has affordable employer sponsored insurance. Changing the family glitch would help lower income immigrant populations, just as it would citizens.

LIMITATIONS

Generalizability of results

Due to a small sample size of only 8 participants and a maximum of three assisters per case population, the results may not be generalizable to other assisters serving similar or different populations. The results may only reflect the perceptions of the assisters that were interviewed and may not reflect the experiences of other in-person assisters.

The timing of the study may also limit the impact of the findings. The barriers the assister is presented with may, in part, be due to the current state of the marketplace and timing of the interview. CMS may alter the marketplace so that some barriers and strategies may only be applicable during this enrollment period and may become irrelevant in the near future. Adjustments are consistently being made and the environment of enrollment is constantly evolving. It can further be mentioned that qualitative data is based on the reality of the moment, is not necessarily reflective of future perceptions, and cannot be replicated in a manner that will yield the exact same results (Merriam, 2009).

Self-reported Data May Be Inaccurate

Self-reported data may reflect social desirability bias. For example, in order to convey success in their work, assisters may report fewer barriers to the researcher than were actually experienced or false strategies for mitigating those barriers to convey success in one's job.

Experience of the Researcher

Because the researcher works as a navigator and has experience assisting immigrants and refugees with the marketplace, she may have a preconceived view of the barriers and strategies that other assisters have had, and may have projected her own experiences unknowingly in the analysis of her data or the manner in which she frames her questions. She tried to limit this bias through respondent validation, meaning she solicited feedback from some of the people that she interviewed to ensure that her interpretations were correct (Merriam, 2009).

CONCLUSION

North Carolina has a high population of immigrants that encounter many barriers in trying to reach the healthcare services that they need. Like the general North Carolina population, immigrants who remain uninsured often do not utilize necessary medical care because of affordability barriers. Remaining uninsured and risking personal health can jeopardize public health overall and place a fiscal burden on the overall population. In the past, health insurance coverage was unavailable to most people who were not provided employer based coverage or public insurance due to high costs. The Affordable Care Act attempted to create opportunities for legal residents to afford health insurance coverage in order to make medical care more accessible to all. North Carolina has utilized the federal marketplace to enroll consumers in qualified health plans offered by private insurers at decreased prices based on the consumer's income.

Consumers of the Latino, refugee, and migrant farmworker populations in North Carolina face complicated barriers in signing up for ACA health coverage that require patience, diligence, perseverance, and creativity from assisters. While these complicated barriers differ based on the specific needs and challenges of each population and/or for specific consumers, coalitions across the state set the strategies for targeting different populations and coordinating enrollment efforts. Assisters that target these populations can mitigate many barriers by learning from each other, sharing resources, and spreading best practices.

Moving forward, it will be important for coalitions in North Carolina to strategically plan and consider what populations are at the highest risk of being uninsured and which populations need the most help to enroll. Eventually, policymakers could adjust policies so that they accommodate the needs of certain populations in more specific ways that fit their common circumstances. It is the hope and vision of the researcher that in future years the number of uninsured immigrants in North Carolina will continue to decrease each year due to lessened barriers to signing up for ACA health insurance coverage, and that consumers in these populations will be able to access the healthcare services that they need.

Appendix A:

Immigrants Who Qualify to Use the Marketplace	People with These Statuses may also apply	People with Following Statuses and Who have Employment Authorization
Lawful Permanent Resident (LPR/ Green Card Holder)	Temporary Protected Status with Employment Authorization	Registry Applicants
Asylee	Special Immigrant Juvenile Status	Order of Supervision
Refugee	Victim of Trafficking Visa	Applicant for Cancellation of Removal or Suspension of Deportation
Cuban/Haitian Entrant	Adjustment to LPR Status	Applicant for Legalization under IRCA
Paroled into the U.S.	Asylum (if they have been granted employment authorization, are under the age of 14, and have had a pending application for at least 180 days)	Legalization under the LIFE Act
Conditional Entrant Granted before 1980	Withholding of Deportation, or Withholding of Removal, under the immigration laws or under CAT	
Battered Spouse, Child and Parent		
Victim of Trafficking and his/her Spouse, Child, Sibling or Parent		
Granted Withholding of Deportation of Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)		
Individual with Non-immigrant Status (includes worker visas i.e. H-2A, H-2B, H-1B, etc, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)		
Temporary Protected Status (TPS)		
Deferred Enforced Departure (DED)		
Lawful Temporary Resident		
Administrative order staying removal issued by the Department of Homeland Security		
Member of a federally-recognized Indian tribe or American Indian Born in Canada		
Resident of American Samoa		

Date Retrieved from healthcare.gov

*Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance)

Appendix B:

Interview questions

I am completing this interview as a part of my Senior Honors Thesis—to hear about the experiences and perspectives of assisters helping immigrants/refugees/temporary migrant workers get health insurance through the federal marketplace. I hope to use this information to identify best practices that they can share with other assisters. I am using your perspective to learn, so if you have any questions or concerns throughout the interview, please interrupt and ask. Your information will be collected and aggregated with data that I obtain from other organizations doing outreach, education, and in-person assistance with similar populations. I will not attribute any quote to you or your agency unless I first obtain permission from you.

Your participation in this interview is voluntary, and you are free to stop the interview at any time. Also, you can decide not to answer any specific question if you do not want to do so.

Before we start, I just want to make sure that you are OK with us taping this interview. Is that OK? Yes/No.

I wanted to double check to see if you are OK proceeding with the interview. Yes/No.

Organization

First, I would like to know a little about you and your organization and the resources that you use for enrollment activities.

1. To start, can you share with me the type and structure of your organization
    - *Probe: Legal Aid, FQHC, Refugee, or Asylee Org, Other*
    - *Probe: What type of assister organization are you? (e.g. navigator, FQHC funded, CAC) and do you receive funding for your ACA enrollment activities? (If yes than from whom?)*
2. What types of services does your organization provide to people in the XX community? (e.g. just enrollment, or does it provide other services, such as legal services, health care services, etc.)
3. Did your organization conduct ACA enrollment during Open Enrollment 1? The special enrollment period? Open Enrollment 2?
4. Is ACA related work one of the primary responsibilities in your organization?
    - *Probe: How much time do you spend on ACA related responsibilities?*
    - *Probe: Approximately how many consumers have you personally assisted?*
    - *Probe: Approximately how many of those consumers were within the XX population?*
5. Does your organization work in a partnership or with other community organizations to reach the XX population?
    - *Probe: If yes, could you describe the nature of these relationships?*

- *Probe: If yes, could you describe the type of work that the organizations do together? (i.e. outreach events, education events, collaboration, enrollment events)*

Describing the Population

Now I'd like to ask you about XX population that you serve

1. Can you describe your average consumer's past experience with accessing the healthcare services that they need? As a reminder, I only want you to focus on the XX population.
    - *Probe: Do these consumers encounter barriers accessing services? If so, please describe? (Language, financial, cultural, other)?*
2. Can you describe your average consumer of XX population's past knowledge of or experience with healthcare coverage?
    - *Probe: Have most had health insurance in the past in America?*
    - *Probe: Can you describe their level of understanding of the importance of insurance and their understanding of how insurance coverage works?*
    - *Probe: Are there any cultural factors within the XX population that make it easier or harder to explain the concepts of health insurance coverage? If yes, please explain these cultural differences and your strategy, if any, to help explain the concepts of health insurance coverage.*
    - *Probe: Can you describe the average consumer in XX population's level of understanding of the Affordable Care Act?*
3. Do consumers of XX population have fears about the ACA that are related to their immigration status? If so, what are they?
    - *Probe: what is your strategy, if any, to address these fears?*

Marketing, Outreach, and Education:

We are defining marketing as a manner of communication to reach a desired population to promote your services pertaining to ACA marketplace enrollment. Outreach and education are defined for the purposes of this interview as efforts to reach and educate a desired population about ACA coverage requirements, the importance of health insurance coverage, and where people can go for more help.

1. Have you found that there is a particular method of marketing or communication that works best to spread news to the XX population about the ACA generally, or enrollment resources more specifically?
    - *Probe: Have you used newspapers, radio, brochures, relied on other organizations to educate the targeted population, word of mouth from other consumers you helped, etc?*
2. What types of education and outreach, if any, do you or your organization do for the XX population that you serve concerning the ACA?
    - *Probe: If any, have there been certain types of outreach that have been more successful than other types?*

3. What lessons did you learn from your marketing, education or outreach efforts that you would want to share with other communities? (Both positive and negative)

Helping People Enroll

1. What is the nature and setting of the enrollment assistance that you give? i.e. hours, frequency, by appointment or walk-in, office setting, clinical setting, at enrollment events or elsewhere
    - *Probe: Are there situations that prevent a consumer of this population from being able to attend enrollment sessions? If so, please explain.*
2. What types of documentation do you ask the consumer to bring to an appointment? Does this differ from the types of documentation you ask for other consumers?
3. On average, about how long does it take to help enroll a consumer of XX population in a health plan (e.g. number of visits, number of hours/visit)? Does this differ from your general population?

Now I'd like to ask you about any problems you might have encountered in the marketplace application that is directly related to the XX population's immigration status:

4. Are there technical problems that you have experienced in helping the XX population enroll into coverage that is different from, or more difficult than for the general population? (Examples: identify verification, immigration-related documentation problems, or problems accessing the population?)
    - *Probe: Have you discovered any workarounds? If so, what?*
    - *What lessons have you learned that could help other assisters who are working with this population?*

Now I'd like to ask you questions about other barriers—unrelated to the website or federal hotline—that may cause problems with the enrollment process:

5. Please describe how you address the language needs of the XX population?
    - *Probe: Do you find that you are able to communicate effectively with the XX population to help them successfully enroll?*
    - *Probe: Do you speak the same native language as a consumer of this population?*
    - *If no, how do you provide language services?*
    - *Probe: Do you have translated materials in XX language to provide the XX population? If so, what types of materials are they and where did you obtain them (e.g. healthcare.gov or other nonprofits)*
    - *What lessons would you suggest to other organizations serving the XX community in terms of helping meet their language needs?*
6. Are there any cultural beliefs that create barriers for this population to seek insurance coverage? (e.g. there is no private insurance in their country of origin, or they rely more heavily on nontraditional medicine and not Western medicine)?
    - *Probe: Is this different than for the general population? If so, how?*

- *Probe: Do you have any strategies to explain the importance of insurance or about different insurance concepts for members of XX population?*
- *Have you learned any lessons that could help other assisters who are working with this population?*

7. Are there other barriers that you have encountered in helping members of XX population enroll? (e.g. Computer skills, lack of computer at home, lack of email, literacy)
    - *Probe: Is this different from the general population you serve?*
    - *Probe: How do you address these barriers?*
8. Are there any facilitators that make it easier for you to work with this population (e.g. are they more interested in gaining health insurance coverage than other populations? More interested in complying with the new laws? Etc.)
9. Overall, do you think there are specific skills that the assister needs in working with this population?
    - *Probe: i.e. should an assister be people person, be good at explaining technical, complicated terms in a simplistic way, have knowledge about cultural differences or different immigration statuses?*

After the appointment/Education:

1. Are there any tips and resources that you provide to your consumers after they have selected a plan? If so, please describe.
    - *Probe: Does this differ from what you provide the general population you serve?*
2. Do you conduct any follow-up with consumers to ensure that their health insurance coverage has worked out/ they understand their responsibilities and the provisions of their insurance?
    - *Probe: If yes, what contact is usually made after an initial appointment?*
    - *Is this different from what you do for your general population?*
3. Do you have an idea of the satisfaction level of their insurance plan of those within the population who have enrolled?

Final Questions

1. What, if any, evaluation has been conducted to measure ACA related efforts as it relates to the XX population? Have you received feedback from members of this population, or other organizations that serve this population about the education, outreach, or enrollment services you provided?
    - *Probe: If you have received feedback, what did you learn?*
    - *Probe: Have you made any changes to your marketing, education, outreach, or enrollment events based on this feedback?*
2. *Earlier, you noted that you also serve the YY, ZZ immigrant population(s). Is your experience working with the XX population different from your experiences working with YY, ZZ populations? If so, how?*

3. Do you have any suggestions for assisters in other organizations that would like to work with this type of population?

- *Probe: Keys to success?*

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